Before the Federal Communications Commission
Washington, D.C. 20554

In the Matter of:

Notice of Proposed Rulemaking (NPRM)	) WC Docket No. 02-60
Regarding the Universal Service Support	)
Mechanism for Rural Healthcare	)

Joint Comments of the Texas Health Information Network Collaborative (THINC) and CHRISTUS Health

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The Texas Health Information Collaborative (THINC) and CHRISTUS Health welcome this opportunity to jointly comment on the Federal Communications Commission's (FCC or Commission) Notice of Proposed Rulemaking regarding the Universal Service support mechanism for health care providers (NPRM).

THINC is the recipient in Texas of the FCC's Rural Health Care Pilot Program (RHCPP) and a not for profit organization that is working with many other organizations in Texas, including the public-private partnership established by the state legislature the Texas Health Services Authority (THSA) which is responsible for overseeing initiatives that improve access to care and the quality and efficiency of care for all Texans. CHRISTUS Health is the fiduciary for THINC. THSA is the state designated HIE entity for Texas.

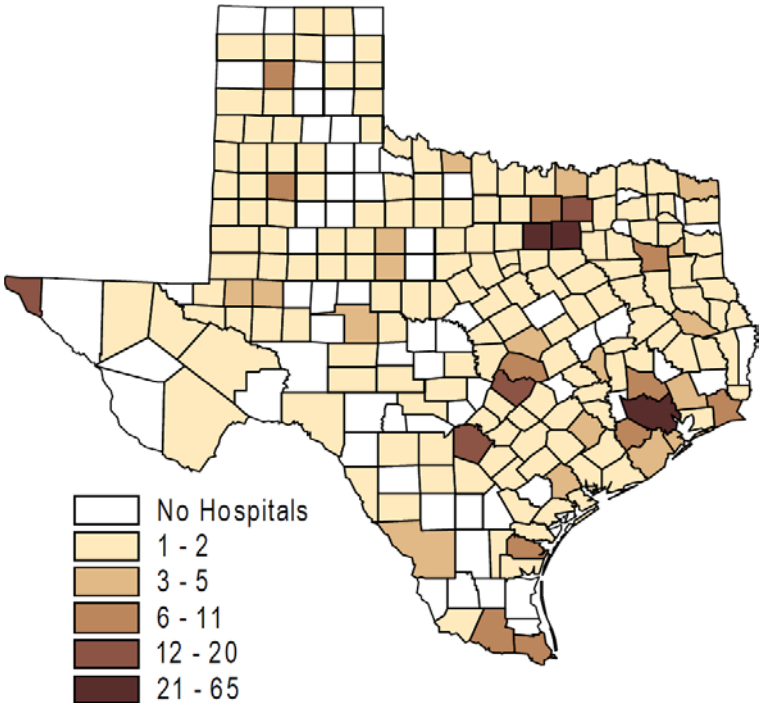
Texas is a unique state, one of many contrasts. It is the second largest state in terms of geographic area as well as population, with 25.5 million residents, represents a broad range of geographic and cultural (population) diversity which carries forward into health care delivery. More than 50 percent of the 254 counties in Texas meet the federally recognized standards for rural designation and share the characteristics and challenges faced by rural communities elsewhere. Rural Texas covers approximately 80 percent of the state's total area, encompassing 213,302 square miles out of 268,581. As of January 1, 2007, Texas has the largest rural population in the nation with 3,296,378 rural residents.

On the other hand, five of the major urban areas meet and/or exceed populations of 25 states across the country.

Additionally, Texas shares the longest international border (Mexico) of any state, further differentiating its unique characteristics and diversity as well as adding a level of complexity to its needs.

This unique landscape provides numerous challenges and opportunities regarding providing access to health care services to rural Texans. Many counties do not have a hospital. Some counties have no physician and others have one or two. Some rural areas stretch for fifty miles and more, while others abut some of the largest cities in the nation.

The following map shows the density of hospitals across the state.



We commend the Commission for its revisions to the Rural Health Program and for developing a plan with the magnitude of changes as presented in the notice.

While we could comment at length, THINC prefers to focus on a few issues on which to comment.

Health Infrastructure Program

1. Determination of inadequacy of existing broadband infrastructure

We encourage the Commission to consider other determinants of the inadequacy of broadband infrastructure apart from those in the proposed rule, especially those that consider bandwidth and financial analysis. Bandwidth claims are sometimes difficult to verify so an advertised rate should not be the sole determinant.

We also encourage the Commission to consider affordability as important a determinant of broadband infrastructure, equivalent to any other factor. We recommend that urban areas

be included and that the program not be limited to rural areas. While this at first seem counter-intuitive to a rural health program, telehealth and eCare has progressed to the point where the location of specialty providers amongst other services, is less important than it was prior to advances in communication technology. Located within most of our urban centers are islands of persons who cannot afford subscription fees for broadband services. More infrastructure will not help these providers or the individuals they serve. Including urban facilities that connect with rural facilities, as the RHCPP has demonstrated successfully, can be a formidable approach to improving access to care while increasing broadband use and sustainability.

2. Administrative Costs

The experience of some of the RHCPP initiatives underscores the need for administrative cost support. We appreciate the Commission recognizing this need and recommend that the annual amount is set at a minimum of $200,000. Multiple skill sets are required and allowing for the ability to engage a variety of persons with a variety of skills will aid the success of each project.

3. Designation of Successor Projects

This recommendation addresses the inability of a project to meet its obligations and sets methodologies to either name a successor organization or redirect funding.

The Proposed Rule does not appear to address directly the current RHCPP initiatives and how they may continue to build upon the work they have started, with the exception of paragraph 113. While the pilot program may come to and from the FCC's perspective, the networks in place will not. Requiring them to undergo another round of bidding would be expensive and prohibitive. Due to their unique nature as consortia representing a variety of urban and rural eligible providers, the rules for how they can continue appear to require an unwinding or undoing of some of the participants. These projects provided much of the experiential evidence that resulted in some of the proposed rules. We recommend the Commission provide a means for current RHCPP projects to continue to build upon their foundations and prioritize funding for projects that build on and coordinate with RHCPP-funded networks and for projects that demonstrate their knowledge of and coordination with related federal programs.

The revised Rural Health Program should ensure that the consortia organizations that were created as part of the Rural Health Care Pilot Program are enabled to effectively participate in the revised program without impediments.

Health Broadband Services Program

1. Minimum Level of Broadband Capability

Communications technology and capabilities continue to progress and become unified at the same time. Quality of Service, reliability, transferring images simultaneously with video conferencing and data transfer will require greater bandwidth capacities than currently in use at most facilities. We understand the rationale behind a minimum. With convergence and the requirements by HHS that health providers "exchange information" we are concerned that setting a minimum may be viewed also as a maximum. Unless the minimum is set high enough it may prove to be troublesome. We recommend 100Mbs for the smallest practice as the bare minimum that should be required.

2. Eligible Facilities

Network operations and management along with the provision of health care services requires administrative personnel and data centers. We strongly recommend that the Commission deem as eligible as many facility types as it possibly can to participate in the Healthcare Broadband Services Program.

In addition to non-care providing facilities, hospice, long term care, nursing homes and any other facility that provides care should also be deemed eligible.

Additional Comments and Recommendations

1. Inter-Agency Cooperation and Coordination

The American Reconstruction and Recovery Act (ARRA) of 2009 included a number of initiatives focusing on the expansion of broadband across the country. A variety of agencies were a part of the initiative including Commerce, Agriculture, the FCC and HHS. While we understand the challenges of coordinating across multiple agencies, the benefits of inter agency coordination especially around infrastructure projects would allow for more concentrated leveraging of opportunities.

2. Meaningful Use as a Driver

The Proposed Rule includes a section on "Meaningful Use." We are pleased that both the National Broadband Plan and the Proposed Rule acknowledge the role meaningful use plays in driving the necessity for broadband connectivity by providers. Meaningful use is a methodology developed and required by the Office of the National Coordinator (ONC), which is a component of the Department of Health and Human Services (HHS).

From the inception of the RHCPP, HHS declared it was a co-sponsor. The quarterly report required of every RHCCP participant includes two questions about how we are supporting HHS goals and objectives. There is an outstanding opportunity to coordinate the purposes of meaningful use with the National Broadband Plan. Individual providers must achieve meaningful use which requires some type of network connectivity in order to exchange information. Allowing individual physicians and other providers to connect to the network would better align agencies goals while furthering the goal of inter-agency sponsorship of the pilot program.

3. Urban v Rural

As stated above, Texas may represent the ultimate paradox of urban/rural more so than most others. We certainly understand the need for broadband services in the rural areas of the state and at sufficient bandwidth to allow for a variety of health services to be accomplished.

While broadband may be available in the urban setting, affordability remains an issue for many providers.

We therefore recommend that the Commission consider a commercial "health services network rate" that would have sufficient bandwidth that would offer limited non-health related services. As coordinated care and accountable care organizations develop and grow, the need to connect individuals with their care team will also grow. The plan does not address individual access to broadband services. As personal medical devices and remote monitoring continue to grow and originate not from health facilities but from people's homes, we encourage the Commission to consider a "health services" connectivity rate that will allow care providers and facilities to connect with their patients and publics. The additional usage should offset investment costs of installation and build out.

4. Affordability

The best way to assure growth of broadband is to make it affordable to all its end users. As stated above, we recommend that the Commission consider a "health services" rate for individual broadband subscribers that will allow us to bring telehealth and eCare not only to a facility but to a person's home or mobile device.

5. Access to Broadband versus Ownership of Broadband

Many health systems may have their own networks that connect their various facilities with one another. The majority of these systems do not own the broadband network. Nor is it a priority. Health care delivery is challenging and owning a private network usually requires too heavy an investment in infrastructure.

We recommend that the Commission focus on access to broadband and not ownership of broadband.

Thank you for the opportunity to comment on the proposed rule.